DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Occupational Safety and Health
San Francisco District Office
455 Golden Gate Avenue, Suite 9516
San Francisco, CA 94102
Tel. # (415) 557-0100 Fax # (415) 557-0123



## NOTICE OF INTENT TO CLASSIFY CITATION AS SERIOUS

Via personal delivery, first class mail with proof of service, or fax

March 26, 2020

San Francisco General Hospital Attention: Susan Brajkovic Michael Harris & Daphne Nguyen 1001 Potrero Ave San Francisco, CA 94110

Dear Employer:

An inspection was opened by Channing Sheets at a place of employment located at 1001 Potrero Ave, San Francisco, CA 94110 on 10/24/2019. The purpose of this form is to inform you that pursuant to Labor Code Section 6432, the Division intends to cite as "serious" the following alleged violation:

Prior to and during the course of inspection, employer failed to include in its workplace violence prevention plan was not effectively establish, implemented, and maintained in that not all the required elements in were addressed.

- 1. The employer failed to effectively implement its procedures for ensuring that employees were involved in procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including their participation in identifying, evaluating, and correcting workplace violence hazards during site inspections, designing and implementing training, and reporting and investigating workplace violence incidents.
- a. Employees were excluded from workplace violence committee meetings. [Ref: 33429(c)(2)]
- b. Employer failed to solicit feedback from employees on the training of physicians and residents on the site specific workplace violence procedures. [Ref: 33429(c)(2) & (c)(8)]
- c. Employee under-reported workplace violence incidents due to poor feedback on resolutions from the employer. [Ref: 33429(c)[2]]
- 2. The employer failed to coordinate implementation of its procedures with employees of other employers working in the same health care facility, service, or operation, to ensure that those employers and employees understand their respective roles as provided in the Plan including training on how incidents are reported, investigated, and recorded.
- a. The employer did not address this item for physicians, residents, and travel nurses. The employer did not provided the same training to all staff working in the psychiatric units and emergency departments. [Ref:3342(c)(3) & (c)(8)]
- b. Psychiatric technicians working in the emergency department were not trained on the site specific procedures used in the behavioral health rooms in POD A. [Ref: 3342(c)(3)]
- 3. The employer failed to ensure that law enforcement obtaining assistance from the appropriate law enforcement agency during all work shifts including a policy statement prohibiting the employer from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.
- a. The employees were retaliated against for wanting to press charges against patients.
- b. An employee was not allowed to get a restraining order against a patient with a history of biting.
- c. The employer encouraged law enforcement to cite and release patients that assaulted employees. [Ref: 3342(c)(4)]
- 4. The employer's managers have made harassing statements and taken retaliatory actions against staff. The employer has not effectively implemented its retaliation procedures for type 3 violence. [Ref: 3342(c)(5)]

- 5. The employer failed to ensure that its supervisors comply with the plan in accordance with Section 3203(a)(2). [Ref: 3342(c)(6)]
- 6. The employer did not effectively implement its communication with employees regarding workplace violence matters, including:
- a. The employer did not communicate workplace violence concerns without fear of reprisal.
- b. The employer would notify the employees that a workplace violence incident investigation was closed, but failed to communicate the corrective actions taken to staff. [Ref:3342 (c)(7)]
- 7. The employer failed to effectively identify and evaluate environmental risk factors including;
- a. The lack of staff at triage when staff are required to lock up patients personal items.
- b. The hazard posed when patients are placed in the hallway on gurneys while in restraints and seclusion rooms are full.
- c. The doubling up of restrained and unrestrained patients in ER rooms. [Ref: 3342(c)(9)(A)(2) & (c)(9)(A)(3)]
- d. Homeless patients that wander beyond the main lobby to the upper floors leading to disruptions. [Ref: 3342(c)(9)(A)(3) & (c)(9)(A)(7)]
- e. RFPC Clinic exam rooms with obstructed access to the door. [Ref: 3342(c)(9)(A)(4)]
- f. No portable alarms in triage, POD C, or resuscitation rooms 3-6 were nurses are isolated. [Ref: 3342(c)(9)(A)(5) & (c)(9)(A)(6)]
- 8. The employer failed to identify and evaluate patient specific risk factors when;
- a. A patient with a history of violence comes back for treatment six weeks after previous treatment because the medical recordkeeping system removes the flag after six weeks. [Ref: 3342(10)(C)]
- b. Patients doubled up in behavioral exam rooms in POD A act as triggers for each other. [Ref: 3342 (c)(10)(D)]
- 9. The employer's procedures to correct workplace violence hazards were not effectively implemented in the following instances;
- a. The employer failed to ensure that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. The emergency department and psychiatric units are insufficiently staffed with nurses, MEAs, PCAs, and sheriffs deputies & cadets, and psychiatric technicians. Ref: 3342(c)(11)(B) & (c)(11)(J) & (c)(11)(J) & (c)(11)(J)
- b. The employer failed to provide alarm systems or other effective means for employees working in POD C, triage, or resuscitation rooms 3-6 out of the line of sight. [Ref: 3342(c)(11)(B)]
- c. Physicians called to respond to emergencies in resuscitation were not immediately available to responding to medication request, evaluate patients, and write restraint orders for violent patients in POD A. [Ref: 3342(c)(11)(B)]
- d. When MEAs are pulled away from their sitter (i.e. coaching) assignments in the POD A behavioral examination rooms to the resuscitation area. [Ref: 3342(c)(11)(B)]
- e. Portable alarms in the psychiatric unit that were not working properly. [Ref: 3342 (c)(11)(G)]
- f. The surveillance monitors for the POD A behavioral exam rooms were not operational on October 24, 2019. [Ref: 3342 (c)(11)(G)]
- g. The panic alarm does not communicate between the 7B and 7C units. [Ref: 3342(c)(11)(G)]
- h. The employer's procedures to correct workplace violence hazards did not include effective means by which employees can be alerted to the presence, location, and nature of the security threat for employees working on POD C can notify other PODS when working alone. [Ref: 3342(c)(11)(H)]
- i. The employer's workplace violence correction procedures did not prevent the transport and entry of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons. Patients entered the emergency department with knives and wanding procedures conduct by law enforcement were inconsistent. Ref: 3342(c)(11)(E)]
- 10. Nurses have been assaulted, but the employer failed to remove them from their assignments to;
- a. To immediately provide first aid or referral for additional medical treatment. [Ref: 3342 (c)((12)(A)]
- b. To provide individual trauma counseling [Ref: 3342 (c)((12)(C)]
- c. To conduct a post incident debrief as required [Ref: 3342 (c)((12)(D)]

This alleged violation may be cited as a violation of one or more of the following regulations of Title 8 of the California Code of Regulations, or any other applicable regulation:

8CCR Section 3342(c) Violence Prevention in Healthcare. Workplace Violence Prevention Plan

The Division may also classify the violation as "willful serious" or "repeat serious".

You are encouraged to provide, in writing, any statements and supporting evidence showing that the Division should not classify the citation as "serious". Factors the Division may consider include the following:

1. Training for employees and supervisors relevant to preventing employee exposure to the hazard or to similar hazards

- 2. Procedures for discovering, controlling access to and correcting the hazard or similar hazards
- 3. Supervision of employees exposed or potentially exposed to the hazard
- 4. Procedures for communicating to employees about your health and safety rules and programs
- 5. Any additional information that you wish to provide such as:
  - a. An explanation of the circumstances surrounding the alleged violative events
  - b. Why you believe a serious violation does not exist
  - c. Why you believe your actions related to the alleged violative events were reasonable and responsible

Use "Employer's Signed Response to Notice of Intent to Classify Citation As Serious" form (attached). Additional statements and supporting evidence can be attached to the form. Use a separate form to respond to each "Notice of Intent to Classify Citation As Serious" received from the Division.

Please return the form, along with your additional statements and supporting evidence. Also, attach a copy of this notice. Information received by <u>April 17, 2020</u> will be considered before the Division issues the citation. Information received after this date may not be considered before the Division issues the citation. If no information is received at all, the citation may still be issued.

If you have any questions, please contact me at the phone number or address in the letterhead.

Sincerely.

Denis McComb District Manager

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## **Employer's Signed Response to Notice of Intent to Classify Citation As Serious**

(Please attach additional information and evidence as necessary to support your response and a copy of the Division's "Notice of Intent to Classify Citation As Serious")

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